APPLICATION FOR APPROVAL OF CONTINUING EDUCATION COURSE
Course Provider

Continued competency means a planned learning experience relating to the scope of physical therapy practice as defined by KRS 327.010(1) if the subject is intervention, examination, research, documentation, education or management of health care delivery systems.

Provider Name: _____ **Contact Person:** _____

Address: _____

City/State/Zip: _____ **Phone:** _____

Web Address: _____ **E-Mail:** _____

Exact Program Title:

Program Format:	☐ Lecture/Lab ☐ Video ☐ Correspondence ☐ Online ☐ Other
Key Word/Category: (Please select all that apply)	☐ Acute Care ☐ Aquatic Physical Therapy ☐ Cardiovascular & Pulmonary ☐ Clinical Electrophysiology ☐ Documentation ☐ Education ☐ Geriatrics ☐ Hand Rehabilitation ☐ Health Policy & Administration ☐ Home Health ☐ Management ☐ Neurology ☐ Oncology ☐ Orthopaedic ☐ Payment Policy ☐ Pediatrics ☐ Private Practice ☐ Research ☐ Sports Physical Therapy ☐ Women's Health ☐ Wound Management

Intended Audience: ☐ PT ☐ PTA ☐ Students ☐ Other (specify) _____

Has this program been approved for Continuing Education by another agency or association?

☐ No ☐ Yes (if yes please specify)

Date Approved Agency _____

Contact Hours: (excluding meals and breaks) _____

The following information must accompany this application: (attach course brochure if inclusive of information listed below). Failure to include requested documentation may result in application being delayed or rejected.

1. Timed Outline or Agenda
2. Course Description
3. Course Objectives
4. Program Evaluation
5. Copy of Certificate of Completion (sample)
6. Home-study or online courses must submit a copy of the post-test and the minimum passing score
7. Biographical data for each speaker to include pertinent educational and clinical experience
8. Application fee of $100
9. Include a self addressed, stamped envelope for reply
10. For guidelines on continued competency see APTA's Policy on Professional Development, Lifelong Learning and Continuing Competence.

Signature: _____ **Date:** _____

Return to: **KPTA, P.O. Box 109, Verona, KY, 41092, Phone/Fax: (859) 485-2812, kptaky@gmail.com**

Do not write below this line:

For Office Use Only:

_____ **Denied** **Reason** _____

_____ **Approved** **KPTA Approval #** _____ **Approval Expiration Date** _____

KPTA approval # and expiration date must be included on the course completion certificate

Approval Committee Signature: _____ **Date:** _____